

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OFC 11/6/11

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/22/2011
NAME OF PROVIDER OR SUPPLIER LAKESHORE HEARTLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE NASHVILLE, TN 37214	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of C/O #28903 and #28918 was conducted November 7-22, 2011, at Lakeshore Heartland. No deficiencies were cited for C/O #28918.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	1. Resident #1 is no longer a resident in this facility. 2. RN #1 will be in-serviced by the Director of Nursing and the Treatment Nurse on correct procedures for admission and weekly skin assessments. This in-service will include procedures for incident reports and reporting injuries of unknown origin. The Treatment Nurse will monitor all incident reports and reports of injuries of unknown origin daily for appropriate notification of family and physician. 3. All nursing staff will be in-serviced on the procedures involved in incident reports and injuries of unknown origin. 4. The Director of Nursing will monitor 100% of incident reports and weekly skin assessments until no problems are identified for three consecutive months. After that time the DON will conduct random checks for the next three months to ensure continued compliance.	1/6/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Judy French

Administrator

12/5/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy and interview, the facility failed to notify the family of bruising of an unknown source for one (#1) of eight residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on September 16, 2011, with diagnoses including Hypothyroidism, Compression Fracture, Congestive Heart Failure, Dehydration, Stage 3 Chronic Kidney Disease, Peripheral Vascular Disease, Seizure Disorder, Chronic Low Back Pain, Alzheimer's Dementia, History of Knee Replacement, Bilateral Cataract Surgery, Coronary Artery Disease, Tobacco Abuse, Osteopenia, Deep Vein Thrombosis, Osteoarthritis and Anxiety. Medical record review of the Minimum Data Set dated October 1, 2011, revealed the resident had severely impaired decision-making skills.</p> <p>Medical record review of the admission nursing assessment dated September 19, 2011, revealed the resident had bruises to the legs, a Pressure Ulcer on the right hip and a transparent dressing to the back of the right arm. Continued review revealed the resident had no bruising to the arms.</p> <p>Medical record review of a "Resident Skin Audit/Concern Sheet" completed by Certified Nursing Assistant (CNA) #1 dated September 23, 2011 (four days after admission) revealed the resident had bruising to both arms.</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>Medical record review of a "Head to Toe Skin Check" by Registered Nurse (RN) #1 dated September 24, 2011, (five days after admission) revealed the resident had bruising to the front of both arms extending from below the elbows to the shoulders.</p> <p>Review of the facility's policy for "Incident reports and charting" revealed, "1. When an incident occurs the charge nurse must immediately assess the resident and take appropriate action for medical treatment...2... Family and MD (physician) must be notified..."</p> <p>Telephone interview on November 8, 2011, at 1:45 p.m., with the resident's Power of Attorney (POA) for health care/family member revealed the family was not notified of the bruising to the arms.</p> <p>Interview in the conference room on November 9, 2011, at 4:00 p.m., with the Administrator confirmed the "Incident reports and charting" policy applied to bruising of unknown source and confirmed families would be notified of any bruising of unknown source.</p> <p>Medical record review and interview in the conference room on November 10, 2011, at 10:45 a.m., with the Director of Nursing (DON) confirmed no evidence the family was notified of the bruising of unknown origin identified on September 24, 2011, by the RN #1.</p> <p>Telephone interview on November 10, 2011, at 11:30 a.m., with RN #1 confirmed RN #1 failed to notify the family on September 24, 2011, of the</p>	F 157			

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F 157	Continued From page 3 bruising to the upper arms which extended from below the elbows to the shoulders	F 157			
F 225 SS=D	C/O #28903 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	<ol style="list-style-type: none"> 1. Resident #1 is no longer a resident in this facility. 2. RN #1 will be in-serviced by the Director of Nursing and the Treatment Nurse on correct procedures for admission and weekly skin assessments. This in-service will include procedures for incident reports and reporting injuries of unknown origin. 3. All nursing staff will be in-serviced on the procedures involved in incident reports and injuries of unknown origin. The Treatment Nurse will monitor all incident reports and reports of unknown origin daily for appropriate notification of family, MD and Administrator. The Administrator will report to the state agency any injury determined to be of unknown origin. 4. The Director of Nursing will monitor 100% of incident reports, weekly skin assessments and injuries of unknown origin until no problems, including reporting appropriately to the state agency, are identified for three consecutive months. After that time the DON will conduct random checks for the next three months to ensure continued compliance. 		1/6/2012

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NAME OF PROVIDER OR SUPPLIER

LAKESHORE HEARTLAND

STREET ADDRESS, CITY, STATE, ZIP CODE

3025 FERNBROOK LANE
NASHVILLE, TN 37214

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F 225	<p>Continued From page 4</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policies, and interview, the facility failed to report an allegation of abuse to the State agency and failed to fully investigate an injury of unknown origin for one (#1) of eight residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on September 16, 2011, with diagnoses including Hypothyroidism, Compression Fracture, Congestive Heart Failure, Dehydration, Stage 3 Chronic Kidney Disease, Peripheral Vascular Disease, Seizure Disorder, Chronic Low Back Pain, Alzheimer's Dementia, History of Knee Replacement, Bilateral Cataract Surgery, Coronary Artery Disease, Tobacco Abuse, Osteopenia, Deep Vein Thrombosis, Osteoarthritis and Anxiety. Medical record review of the Minimum Data Set dated October 1, 2011, revealed the resident had severely impaired decision-making skills.</p> <p>Medical record review of the admission nursing assessment dated September 19, 2011, revealed the resident had bruises to the legs, a Pressure Ulcer on the right hip and a transparent dressing to the back of the right arm. Continued review revealed the resident had no bruising to the arms.</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>Medical record review of a "Resident Skin Audit/Concern Sheet" completed by Certified Nursing Assistant (CNA) #1 dated September 23, 2011 (four days after admission) revealed the resident had bruising to both arms.</p> <p>Medical record review of a "Head to Toe Skin Check" by Registered Nurse (RN) #1 dated September 24, 2011 (five days after admission) revealed the resident had bruising to the front of both arms extending from below the elbows to the shoulders.</p> <p>Review of the facility's Abuse Investigations policy revealed, "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management...Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident...The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) as deemed appropriate (handwritten on policy) who have had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and visitors as deemed</p>	F 225			

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F 225	<p>Continued From page 6 appropriate..."</p> <p>Review of the facility's policy for reporting abuse revealed the following: "It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source...to facility management...The Administrator must be immediately notified of suspected abuse...When an alleged or suspected case of mistreatment, neglect, injuries of unknown source...is reported, the facility Administrator, or his/her designee, will immediately (within twenty-four hours of the alleged incident) notify the following persons or agencies of such incident..." Continued review of the policy revealed the following had a line drawn through and initialed by the Administrator: "...a. The State licensing/certification agency responsible for surveying/licensing the facility..."</p> <p>Review of the facility's policy for "Incident reports and charting" revealed, "1. When an incident occurs the charge nurse must immediately assess the resident and take appropriate action for medical treatment. 2. An incident report is to be filled out at this time. It must be filled in completely and all questions answered and vital signs provided...3. Have the person who reported the incident and all witnesses write a statement immediately. If they do not they will be required to return to the facility and do this on their own time. You must also make a statement in writing about the incident. 4. Make a NN (nurse's note) in the resident chart describing exactly what happened to the best of your knowledge. Do not speculate or state what you think happened..."</p>	F 225			

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F 225	Continued From page 7 Interview in the conference room on November 8, 2011, at 11:30 a.m., with the Administrator revealed the facility had not reported any allegations of abuse or injuries of unknown origin to the State agency in the past four months. The Administrator stated, "We're not required to report allegations per State and Federal regulations." The Administrator brought a copy of the Federal regulations to the conference room; read the regulation; and confirmed the regulations required allegations of abuse or injuries of unknown origin be reported to the State agency. Interview in the conference room on November 8, 2011, at 3:50 p.m., with the Administrator confirmed the injury of unknown origin (bruising to the arms) was not reported to the State agency. Telephone interview on November 9, 2011, at 6:30 p.m., with Licensed Practical Nurse (LPN) #1 confirmed LPN #1 assessed the resident's skin condition on admission on September 19, 2011, and confirmed the resident had no bruising on the arms. Interview in the conference room on November 9, 2011, at 10:30 a.m., with CNA #1 confirmed the resident was showered on September 23, 2011, and was observed with bruising to the front of both arms. Medical record review and interview in the conference room on November 10, 2011, at 9:30 a.m., with the Administrator and the Director of Nursing (DON) confirmed the resident had bruising on both arms on September 23, 2011, which was not present on admission (four days	F 225			

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F 225	Continued From page 8 earlier). Continued interview with the Administrator and the DON revealed when staff saw bruises, they were to report the bruising to LPN/Treatment Nurse, and the LPN/Treatment Nurse followed up with assessment of the resident and investigation in an attempt to identify a cause of the bruising. Medical record review and interview in the conference room on November 10, 2011, at 10:40 a.m., with the LPN/Treatment Nurse confirmed the LPN/Treatment Nurse never received an Incident Report for the bruising to the arms and confirmed the cause of the bruising was never investigated. Telephone interview on November 11, 2011, at 11:30 a.m. with RN #1 who documented the bruising to both arms on September 24, 2011, confirmed the resident had bruising from below the elbow to the shoulder at the time of the assessment on September 24, 2011. Continued interview with RN #1 confirmed RN #1 had no recall of completing an incident report related to the bruising and no recall of RN #1 reporting the bruising (which occurred between admission and September 24, 2011), to anyone.	F 225			
F 514 SS=D	C/O #28903 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514			

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F 514	<p>Continued From page 9</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure accurate skin assessments were maintained for one (#1) of eight residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on September 16, 2011, with diagnoses including Hypothyroidism, Compression Fracture, Congestive Heart Failure, Dehydration, Stage 3 Chronic Kidney Disease, Peripheral Vascular Disease, Seizure Disorder, Chronic Low Back Pain, Alzheimer's Dementia, History of Knee Replacement, Bilateral Cataract Surgery, Coronary Artery Disease, Tobacco Abuse, Osteopenia, Deep Vein Thrombosis, Osteoarthritis and Anxiety. Medical record review of the Minimum Data Set dated October 1, 2011, revealed the resident had severely impaired decision-making skills.</p> <p>Medical record review of the admission nursing assessment dated September 19, 2011, revealed the resident had bruises to the legs, a Pressure Ulcer on the right hip and a transparent dressing to the back of the right arm. Continued review</p>	F 514	<ol style="list-style-type: none"> 1. Resident #1 is no longer a resident in this facility. 2. All future admission and weekly skin assessments will be completed by the Treatment Nurse and/or the Weekend Supervisor. 3. RN #1 will be in-serviced by the Director of Nursing and the Treatment Nurse on correct procedures for admission and weekly skin assessments. This in-service will include procedures for incident reports and reporting injuries of unknown origin. All nursing staff will be in-serviced on the procedure to do incident reports and injuries of unknown origin. 4. The Director of Nursing will monitor 100% of incident reports and weekly skin assessments until no problems are identified for three consecutive months. After that time the DON will conduct random checks for the next three months to ensure continued compliance. 		1/6/2012

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F 514	<p>Continued From page 10 revealed the resident had no bruising to the arms.</p> <p>Medical record review of a "Head to Toe Skin Check" by Registered Nurse (RN) #1 dated September 24, 2011, (five days after admission) revealed the resident had bruising to the front of both arms extending from below the elbows to the shoulders.</p> <p>Medical record review of a "Head to Toe Skin Check" by RN #1 dated October 1, 2011, and October 8, 2011, revealed no documentation the resident had any bruises.</p> <p>Medical record review and interview in the conference room on November 9, 2011, at 10:00 a.m., with the LPN/Treatment Nurse confirmed skin assessments dated October 1, 2011, and October 8, 2011, were incomplete and did not include documentation of multiple bruises which were present on the resident from admission to discharge on October 13, 2011.</p> <p>C/O #28903</p>	F 514		

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